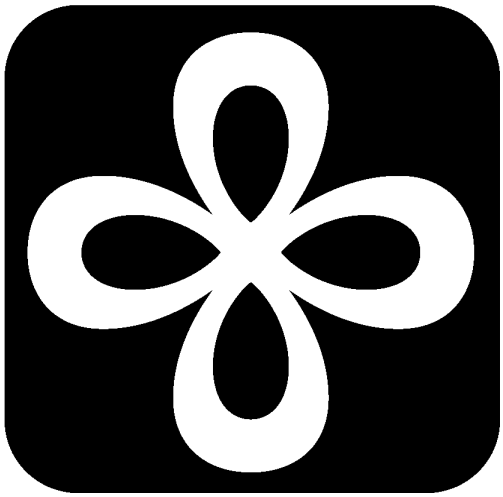
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID



Provider Manual

Optometrist and Optician Services

CHAPTER E. COVERAGE AND LIMITATIONS

CHAPTER F. BILLING AND PAYMENTS Page

APPENDIX

I. PROVIDERS ELIGIBLE TO PARTICIPATE

All optometrists licensed to practice in the state of Iowa or licensed to practice in other states are eligible to participate in Medicaid.

A "therapeutically certified optometrist" is an optometrist who is licensed to practice optometry in this state and who is specifically certified to perform the procedures and employ pharmaceutical agents in accordance with the Iowa Code Chapter 154 regulating the practice of optometry.

All opticians in Iowa or in other states are eligible to participate in Medicaid. **Note:** Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

II. COVERAGE OF SERVICES

Payment will be approved for medically necessary services and supplies provided by an optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limits and exclusions. Covered optometric services include a professional component and materials.

Payment will be approved only for certain services and supplies provided by opticians. Payment will be made for services only when prescribed by a physician (M.D. or D.O.) or an optometrist (O.D.).

Eye examinations, medical services, and auxiliary procedures listed below are not covered for opticians. Lens and frame services are covered for both optometrists and opticians.

A. Professional Services Covered

1. Eye Examinations

The coverage of eye examinations depends on the purpose of the examination. Routine eye examinations are covered once in a 12-month period. Use the diagnosis code V72.0 and the applicable CPT procedure code when billing a routine eye examination.

Nonroutine eye exams are covered when the examination is the result of a complaint or symptom of an eye disease or injury. Use the applicable diagnosis code when billing nonroutine eye examinations.

The following levels of service are recognized for optometric examinations:

- Intermediate Examination: A level of optometric or ophthalmological service pertaining to medical examination and evaluation with initiation or continuation of a diagnostic and treatment program.
- Comprehensive Examination: A level of optometric or ophthalmological service pertaining to medical examination and evaluation with initiation or continuation of a diagnostic and treatment program and a general evaluation of the complete visual system.

2. Medical Services

Payment will be approved for medically necessary services and supplies within the scope of practice of an optometrist. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

3. Auxiliary Procedures

Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis. The following auxiliary procedures and special tests are payable when performed by an optometrist.

- Serial tonometry. Single tonometry is part of the intermediate and comprehensive examinations and is not payable as a separate procedure. Serial tonometry is a payable benefit.
- Gonioscopy.
- Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examinations and, if performed in conjunction with that level of service, is not payable as a separate service procedure.
- Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

- External photography.
- Fundus photography.
- Retinal integrity evaluation.

4. Single Vision and Multifocal Lens Service

When lenses are necessary, the following professional and technical optometric services shall be provided:

- Ordering of corrective lenses
- Verification of lenses after fabrication
- Adjustment and alignment of completed lens orders

When there is a lens correction, new lenses are limited as follows:

- Up to 3 times for children up to 1 year of age
- Up to 4 times per year for children 1 through 3 years of age
- Once every 12 months for children 4 through 7 years of age
- Once every 24 months after 8 years of age

Protective lenses are allowed for:

- Children through 7 years of age
- Recipients with adequate vision in one eye
- Recipients with a diagnosis related illness or disability where regular lenses would pose a safety risk

5. Frame Services

Frame services are payable only when lenses are provided. See Prior Authorization, Section D.

- Selection and styling
- Sizing and measurements
- Fitting and adjustment
- Readjustment and servicing

New frames are limited as follows:

- One frame every 6 months for children through 3 years of age
- One frame every 12 months for children 4 through 6 years of age
- When there is a prescribed lens change and the new lenses cannot be accommodated in the current frame

Safety frames are allowed for:

- Children through 7 years of age
- Recipients with a diagnosis related disability or illness where regular frames would pose a safety risk

6. Dispensing Fee

A dispensing fee is payable only when the recipient is provided with a new pair of glasses. A dispensing fee is not applicable when a charge is made for repair or replacement of lenses or frames.

7. Contact Lenses

Preparation and fitting of contact lenses are covered when:

- Required following cataract surgery, for documented keratoconus, or for treatment of acute or chronic eye disease, including aphakia, or
- Vision cannot be corrected with glasses

Prior authorization is not required in these situations.

Up to 8 pairs of contact lenses per year are allowed for children with aphakia, up to one year of age. Up to 4 pairs of contact lenses per year are allowed for children with aphakia age 1 to 3 years.

8. Artificial Eye

Payment will be made for preparation and fitting of an artificial eye when provided by an optometrist or optician.

9. Repairs and Replacement of Frames, Lenses, or Components

Repairs and replacement of frames, lenses, or component parts are covered. Frame front, temples, pads, top of rim, soldering, etc. are covered. Exception: When parts or repairs provided as a courtesy to other customers are provided to Medicaid recipients, charges cannot be billed to Medicaid.

Consider the repair of existing frames before dispensing new frames when:

- It is evident that the repair of existing frames is less costly than providing a new frame, and
- Such repairs would again provide a serviceable frame for the use of the recipient.

A service charge for installing the frame front, temples, pads, top of rim, soldering, etc., may be approved in addition to the materials, providing no other professional service charge or dispensing fee is made. The service fee shall not exceed the dispensing fee for a replacement frame.

10. Replacement of Glasses

Payment will be approved for replacement of glasses when the original glasses have been lost or damaged beyond repair.

Replacement of lost or damaged glasses for adults age 21 and over is limited to once every 12 months, except when the recipient has a mental or physical disability, such as a seizure disorder or mobility problems. Documentation of the disability must be noted on the claim.

When a lens or the frame is damaged beyond repair, only the damaged materials shall be replaced. Consider the repair of existing frames before dispensing new frames when:

- It is evident that the repair of existing frames is less costly than providing a new frame, and
- Such repairs would again provide a serviceable frame for the use of the recipient.

When the original glasses have been lost or damaged beyond repair, you must show the modifier "RP" on the claim form directly after the procedure code for replacement lenses and frames. Failure to use this modifier will result in denial of the claim if the recipient had previously received glasses in the last two years.

B. Place of Service

Payment is made for services provided to the recipient in the optometrist's office or clinic, the recipient's home, nursing facility, or other appropriate setting.

Use the procedure code for a house call if it is necessary for the professional's service to be provided in the recipient's home or place of residence because the recipient's condition prohibits traveling to the office. Only one house call shall be paid per pair of glasses. No payment is made for subsequent care.

Use the procedure code for an office call if:

- The recipient is called back to the office for a progress report, or
- The recipient is having minor problems and needs to be rechecked, or
- For a miscellaneous minor examination.

This procedure cannot be billed on the same date of service as any specific itemized services, e.g., eye examination, glasses, lenses, or frames. If other patients are not charged, Medicaid cannot be billed.

1. Mileage

Payment for mileage for services provided outside the office may be made under the following conditions:

- It is necessary for the optometrist to travel outside the community to visit the recipient, and
- There are no optometrists in the community in which the recipient is located.

If a charge is made for mileage, the circumstances must be noted on the claim. If more than one recipient is seen during the visit, only one charge for mileage will be approved.

2. Nursing Home Visits

Nursing home visits are not covered for opticians. The following policies apply to optometrists visits to skilled nursing facilities and intermediate care facilities.

- Payment will usually be approved for only one visit to the same recipient in a calendar month. This stipulation presumes the recipient residing in a nursing home has a condition that makes a visit medically necessary. Payment for further visits will be made only if the optometrist adequately substantiates the need for each visit on the claim form.
- When only one recipient is seen in a single nursing home visit, payment is based on a follow-up office visit. The reason for this policy is:
  - The level of service is ordinarily comparable to that furnished in an office setting, and
  - When a larger group of recipients is seen in a nursing home, the circumstances are much the same as if the nursing home were a second office.

  In the absence of information on the claim, the fiscal agent will assume that more than one recipient was seen. Payment will be approved on the basis of a follow-up office call.

Payment will be made for mileage in connection with nursing home visits under the following conditions:

- If it is necessary for the optometrist to travel outside the community to visit the nursing home, and
- There are no optometrists in the community in which the nursing home is located. If a charge is made for mileage, the circumstances must be noted on the claim. If more than one recipient is seen at the nursing home, only one charge for mileage will be approved.

C. Materials

Ophthalmic materials that are provided according to the prescription provided by a physician or an optometrist shall meet the following standards:

- Corrected curve lenses, unless clinically contraindicated, manufactured by reputable American manufacturers.
- Standard plastic, plastic and metal combination, or metal frames manufactured by reputable American manufacturers, if available.
- Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

A lens with a correction of plus or minus six diopters can be billed for additional reimbursement. Only one pair of single vision, bifocal, or trifocal lenses may be billed with the lens correction of plus or minus six diopters. For corrections of plus or minus six diopters, attach a prescription to the claim.

Rose tints I and II are to be covered in the cost of the lenses. Glasses with other cosmetic tints or photogray lenses are not covered.

D. Prior Authorization

The physician or optometrist is responsible for requesting the prior authorization and providing the authorization number to the optician for billing.

Prior authorization is required for the following:

- A second lens correction within a 24-month period for recipients 8 years of age and older.

  Approval shall be given when the recipient's vision has at least a five-tenths diopter of change in sphere or cylinder or a ten-degree change in axis in either eye. When submitting the request for prior authorization, indicate the old prescription along with the current prescription.

  Note: New frames will be authorized only when new lenses cannot be accommodated in the current frame.

- Subnormal visual aids, where near visual acuity is greater than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity, as described above, is less than 20/100.

  Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems.

- Visual therapy when warranted by case history or diagnosis, for a period not greater than 90 days. Approved diagnoses are convergence insufficiency and amblyopies. Visual therapy is not covered when provided by opticians.

Other services, such as protective lenses for persons with only one eye, Schroeder shields, or ptosis crutches, are covered when necessary. Explanation of the need for these services shall be attached to the claim.

E. Exclusions on Coverage

Noncovered services include, but are not limited to, the following:

- Glasses with cosmetic gradient tint lenses
- Glasses with photogray lenses
- Sunglasses
- Other eye wear for cosmetic purposes
- Progressive or no-line multifocal lenses
- A second pair of glasses or spare glasses
- Cosmetic surgery
- Experimental medical and surgical procedures
- Any services related to a noncovered service, such as dispensing fees for photogray or other noncovered lenses

III. BASIS OF PAYMENT FOR SERVICES

A. Professional Services

The basis of payment for professional services is the optometrist or optician fee schedule.

B. Materials

The reimbursement for allowed ophthalmic materials is subject to a fee schedule established by the Department or to actual laboratory cost, as evidenced by an attached invoice.

Materials payable by fee schedule are:

- Lenses (single vision or multifocal)
- Frames
- Case for glasses

The fees include payment of rose tints I and II. However, sunglasses, photogray, or cosmetic tinted lenses are not covered.

Materials payable at actual laboratory cost, as evidenced by an attached invoice, are:

- Contact lenses
- Schroeder shield
- Ptosis crutch
- Subnormal visual aids
- Safety frames
- Safety lenses
- Protective lenses for a person with only one eye, even if a corrective lens is not required

Payment for other materials is made at actual laboratory cost. Submit the actual invoice or a copy of the actual invoice issued by the optical company with your claim.

Major laboratories that provide the materials to opticians for Iowa Medicaid recipients must accept the Medicaid fee schedule allowances for lenses and frames provided to Medicaid recipients. Contact the laboratories that are currently providing materials to your practice to determine if they will accept the Medicaid fee schedule allowances. If you have an "in-house" laboratory, it must accept the fixed fee also.

IV. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the American Medical Association Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS). Claims submitted for optometrist services without a procedure code and an ICD-9-CM diagnosis will be denied. When billing a routine eye examination, use the diagnosis code V72.0.

* Identifies codes that are for optometrist billing. The following codes and modifiers should be used when billing for optometric services:

A. Professional Optometrist Services

1. Examinations*

92002	Intermediate exam, new patient
92012	Intermediate exam, established patient
92004	Comprehensive exam, new patient
92014	Comprehensive exam, established patient

2. Office Services: New Patient*

99201 Office or other outpatient visit; requires:

- a problem focused history,
- a problem focused examination, and
- straightforward medical decision making.

99202 Office or other outpatient visit; requires:
- an expanded problem focused history,
- an expanded problem focused examination, and
- straightforward medical decision making.

99203 Office or other outpatient visit; requires:
- a detailed history,
- a detailed examination, and
- medical decision making of low complexity.

99204 Office or other outpatient visit; requires:
- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

99205 Office or other outpatient visit; requires:
- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

3. Office Services: Established Patient*

99211 Office or other outpatient visit; may or may not require the presence of a physician

99212 Office or other outpatient visit; requires at least two of these three components:
- a problem focused history,
- a problem focused examination, or
- straightforward medical decision making.

99213 Office or other outpatient visit; requires at least two of these three components:
- an expanded problem focused history,
- an expanded problem focused examination, or
- medical decision making of low complexity.

99214 Office or other outpatient visit; requires at least two of these three components:
- a detailed history,
- a detailed examination, or
- medical decision making of moderate complexity.

4. Home Services: New Patient*

99341 Home visit, requires these three components:
- a problem focused history,
- a problem focused examination, and
- medical decision making that is straightforward or of low complexity.

99342 Home visit, requires these three components:
- an expanded problem focused history,
- an expanded problem focused examination, and
- medical decision making of moderate complexity.

5. Home Services: Established Patient*

99344 Home visit for the evaluation and management of a new patient which requires these three components:
- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

6. Nursing Facility Services*

99311 Subsequent nursing facility care, per day, requires at least two of these three components:
- a problem focused interval history,
- a problem focused examination, or
- medical decision making that is straightforward or of low complexity.

99312 Subsequent nursing facility care, per day, requires at least two of these three components:
- an expanded problem focused interval history,
- an expanded problem focused examination, and
- medical decision making of moderate complexity.

7. Domiciliary, Rest Home, or Custodial Services: New Patient*

99321 Domiciliary or rest home visit, requires these three components:
- a problem focused interval history,
- a problem focused examination, and
- medical decision making that is straightforward or of low complexity.

99322 Domiciliary or rest home visit, requires these three components:
- an expanded problem focused history,
- an expanded problem focused examination, and
- medical decision making of moderate complexity.

8. Domiciliary, Rest Home, or Custodial Services: Established Patient*

99331 Domiciliary or rest home visit, requires these three components:
- a problem focused interval history,
- a problem focused examination, and
- medical decision making that is straightforward or of low complexity.

99332 Domiciliary or rest home visit, requires these three components:
- an expanded problem focused interval history,
- an expanded problem focused examination, and
- medical decision making of moderate complexity.

99333 Domiciliary or rest home visit, requires these three components:
- a detailed interval history,
- a detailed examination, and
- medical decision making of high complexity.

9. Other Optometrist Services*

65205	Removal of foreign body, external eye; conjunctival superficial
65210	Removal of foreign body, conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220	Removal of foreign body, corneal, without slit lamp
65222	Removal of foreign body, corneal, with slit lamp
65272	Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization
65275	Repair of laceration of cornea
65430	Scraping of cornea, diagnostic, for smear and/or culture
65435	Removal of corneal epithelium, with or without chemocauterization
65436	Removal of corneal epithelium, with application of chelating agent (e.g. EDTA)
66999	Unlisted procedure, anterior segment of eye
67820	Correction of trichiasis, epilation, by forceps only
67825	Correction of trichiasis, epilation, by other than forceps
67850	Destruction of lesion of lid margin (up to 1 cm)
67938	Removal of embedded foreign body, eyelid
67999	Unlisted procedure eyelid
68020	Incision of conjuctiva, drainage of cyst
68040	Expression of conjunctival follicles
68100	Biopsy of conjuctiva
68340	Repair of symblepharon, division of symblepharon, with or without insertion of conformer or contact lens
68399	Unlisted procedure, conjunctiva
68761	Insertion of punctal plugs
68801	Dilation of lacrimal puntum, with or without irrigation
68810	Probing of nasolacrimal duct, with or without irrigation
68840	Probing of lacrimal canaliculi, with or without irrigation
68899	Unlisted procedure, lacrimal system
76516	Ophthalmic biometry by ultrasound echography, A-scan
76519	Ophthalmic biometry by ultrasound echography, A-scan, with intraocular lens power calculation
92015	Determination of refractive state. Billed only when not billing an eye examination

92020	Gonioscopy
92065	Visual therapy
92081	Visual field exam, limited
92082	Visual field exam, intermediate
92083	Visual field exam, extended
92100	Serial tonometry
92120	Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method
92130	Tonography with water provocation
92135	Scanning computerized ophthalmic diagnostic imaging with interpretation and report unilateral
92140	Provocation tests for glaucoma, with interpretation and report, without tonography
92136	Ophthalmic biometry by partial interferometry with introcular lens power calculation
92225	Ophthalmoscopy extended, initial
92226	Ophthalmoscopy extended, subsequent
92230	Fluorescein angioscopy with interpretation and report
92235	Fluorescein angiograph with interpretation and report
92260	Ophthalmodynamometry
92275	Electroretiongraphy with interpretation and report
92283	Color vision examination, extended, e.g., anomaloscope or equivalent
92284	Dark adaptation examination with interpretation and report
92285	External ocular photography
92250	Fundus photography
92316	Prescription of optical and physical characteristics of contact lenses with medical supervision of adaptation and direction of fitting by independent technician, corneal lens for aphakia, both eyes
92499	Unlisted ophthalmological service or procedure
92531	Spontaneous nystagmus, including gaze
92532	Positional nystagmus test
92533	Caloric vestibular test, each irrigation (biaural, bithermal, stimulation constitutes four tests)
92534	Optokinetic nystagmus test

99241	Office consultation for a new or established patient which requires these three components: • a problem focused history, • a problem focused examination, and • straightforward medical decision making.
99251	Inpatient consultation for a new or established patient which requires these three components: • a problem focused history, • a problem focused examination, and • straightforward medical decision making.
V2627	Hydrophilic soft contact lens for corneal bandage
	Other Services
A4262	Temporary, absorbable lacrimal duct implant, each
A4263	Permanent, long term, non-disposable lacrimal duct implant, each

B. Optometrist and Optician Services

The following services are covered when provided by optometrists and opticians. Claims submitted without a procedure code will be denied.

	Contact Fitting
W2023	Dispense and fit contacts
	Frames, Service, Parts and Case
V2020	Total frame
V2025	Deluxe (wrap-around) frames, children up to two years of age
W0013	Case for glasses
W2006	Repair of frames, parts and labor (when new glasses are not dispensed)
W2022	Dispense and fit new frames
S0516	Safety frames

Lens Service

W2005	Repair of lenses, parts and labor (when new glasses are not dispensed)
W2021	Dispense and fit new lenses

C. Optician Services

The following services are covered only for opticians.

V2623	Prosthetic eye, plastic, custom
V2624	Polishing/resurfacing of ocular prosthesis
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2628	Fabrication and fitting of ocular conformer

D. Materials

The following materials are covered when provided by optometrists and opticians.

Single Vision Lenses

V2100	Sphere, single vision, plano to plus or minus 4.00D, per lens
V2101	Sphere, single vision, plus or minus 4.12 or plus or minus 7.00D, per lens
V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00D, per lens
V2103	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens
V2104	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 2.12 or 3.00D cylinder, per lens
V2105	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens

V2106	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, over 6.00 cylinder, per lens
V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, .12 to 2.00D cylinder, per lens
V2108	Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens
V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens
V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00D sphere, over 6.00D cylinder, per lens
V2111	Spherocylinder, single vision, plus or minus 7.25 or plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens
V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder, per lens
V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 2.00D sphere, 4.25 to 6.00 cylinder, per lens
V2114	Spherocylinder, single vision, sphere over plus or minus 12.00D, per lens
V2118	Aniseikonic lens, single vision, per lens
V2199	Not otherwise classified, single vision lens
V2710	Slab off prism, glass or plastic, per lens

Bifocal Vision Lenses

V2200	Sphere, bifocal, plano to plus or minus 4.00D, per lens
V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D, per lens
V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00D, per lens
V2203	Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens

V2204	Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens
V2205	Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens
V2206	Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens
V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens
V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens
V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens
V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens
V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 25 to 2.25D cylinder, per lens
V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens
V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens
V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00D per lens
V2218	Aniseikonic, per lens, bifocal
V2219	Bifocal seg width over 28MM, per lens
V2710	Slab off prism, glass or plastic, per lens

Trifocal Vision Lenses

V2300	Sphere, trifocal, plano to plus or minus 4.00D, per lens
V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00D, per lens
V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00D, per lens

V2303	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens
V2304	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 2.25 to 4.00D cylinder, per lens
V2305	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens
V2306	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens
V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 12 to 2.00D cylinder, per lens
V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens
V2309	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens
V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens
V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 25 to 2.25D cylinder, per lens
V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens
V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens
V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00D, per lens
V2318	Aniseikonic lens, trifocal, sphere over plus or minus 12.00D, per lens
V2319	Trifocal seg width over 28 MM, per lens
V2320	Trifocal add over 3.25D, per lens
V2399	Specialty trifocal, by report
V2710	Slab off prism, glass or plastic, per lens

Aphakia Lenses

V2115	Lenticular (myodisc), per lens, single vision
V2116	Lenticular lens, nonaspheric, per lens, single vision
V2117	Lenticular, aspheric, per lens, single vision
V2215	Lenticular (myodisc), per lens, bifocal
V2216	Lenticular, nonaspheric, per lens, bifocal
V2217	Lenticular, aspheric, per lens, bifocal
V2315	Lenticular (myodisc), per lens, trifocal
V2316	Lenticular, nonaspheric, per lens, trifocal
V2317	Lenticular, aspheric, per lens, trifocal
Note:	For reporting purposes, modifier "VP" may be used after the procedure code to reflect a diagnosis of aphakia.

Variable Asphericity Lens

V2410	Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430	Variable asphericity lens, bifocal, full field, glass or plastic, per lens
V2499	Variable sphericity lens, other type

Contact Lenses (attach invoice)

V2500	Contact lens, PMMA, spherical, per lens
V2501	Contact lens, PMMA, toric or prism ballast, per lens
V2502	Contact lens, PMMA, bifocal, per lens
V2510	Contact lens, gas-permeable, spherical, per lens
V2511	Contact lens, gas-permeable, toric, prism ballast, per lens
V2512	Contact lens, gas-permeable, bifocal, per lens
V2513	Contact lens, gas-permeable, extended-wear, per lens
V2520	Contact lens, hydrophilic, spherical, per lens

V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens
V2522	Contact lens, hydrophilic, bifocal, per lens
V2523	Contact lens, hydrophilic, extended wear, per lens
V2530	Contact lens, scleral, per lens
V2599	Contact lens, other type

Subnormal Visual Aids

Prior authorization is required for subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2 M print.

V2600	Hand-held low-vision aids and other nonspectacle-mounted aids
V2610	Single-lens spectacle-mounted low-vision aids
V2615	Telescopic and other compound-lens system, including distance vision telescopic, near-vision telescopic, and compound microscopic lens system

When visual acuity is 20/100 or worse, prior authorization is not required. Use codes above and document on the claim that visual acuity is less than 20/100.

Miscellaneous

V2799	Vision service, miscellaneous
S0580	Safety lenses. Use this in addition to the basic code for lens.

Modifiers

RP	Replacement of lost or broken frames or lenses
VP	Diagnosis of aphakia
EP	Service provided as a result of a Care for Kids (EPSDT) examination

I. REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS

A. How to Use

For services requiring prior approval (see **Chapter E**) you must complete form 470-0829, *Request for Prior Authorization*, and submit it to the fiscal agent. Do not use this form unless Medicaid requires prior approval for the service being provided.

The Medical Unit will review the request and make a determination of coverage. When a determination has been made, the form will be returned to you. If the service is approved for coverage, you may then submit your claim for reimbursement.

Important: Do not return the prior authorization form. Place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, the computer will then verify that the service has been approved for payment.

B. Facsimile of Request for Prior Authorization

(See page 3 for a facsimile of form 470-0829.)

C. Instructions for Completing Request for Prior Authorization

1. PATIENT NAME
   Complete the last name, first name and middle initial of the patient. Use the *Medical Assistance Eligibility Card* for verification.

2. PATIENT IDENTIFICATION NUMBER
   Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight characters in length (seven digits and one letter).

3. COUNTY NO.
   This is the number of the county where the recipient resides. It may be copied from the *Medical Assistance Eligibility Card*. This is a two-digit code. This area is optional.

4. DATE OF BIRTH
   Copy the patient's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).

5. PROVIDER PHONE NO.
   Completing this area may expedite the processing of your *Request for Prior Authorization*. This area is optional.

6. PROVIDER NO.
   Leave blank.

7. PAY TO PROVIDER NO.
   Enter the seven-digit provider number assigned to you by the Iowa Medicaid Program.

8. DATES COVERED BY THIS REQUEST
   Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM, DD, YY). If this request is approved, it will be valid only for this period of time.

9. PROVIDER NAME
   Enter the name of the provider requesting prior authorization.

10. STREET ADDRESS
    Enter the street address of the provider requesting prior authorization.

11. CITY, STATE, ZIP
    Enter the city, state and zip of the provider requesting prior authorization.

12. PRIOR AUTHORIZATION NO.
    Leave blank. The fiscal agent will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.

Iowa Department of Human Services

REQUEST FOR PRIOR AUTHORIZATION

(PLEASE TYPE - ACCURACY IS IMPORTANT)

1. Patient Name (Last) (First) (Initial)			2. Patient Identification No.	3. Co. No.	4. Date of Birth Mo. Day Year
5. Provider Phone No.	6. Provider No.	7. Pay to Provider No.	8. Dates Covered by Request		
9. Provider Name			From: Mo. / Day / Year	To: Mo. / Day / Year	
10. Street Address			12. PRIOR AUTHORIZATION NO. (To be assigned by fiscal agent) Enter this number in the appropriate box when submitting the claim form for the services authorized.		
11. City, State, Zip					

13. Reasons For Request (use additional sheet if necessary)

SERVICES TO BE AUTHORIZED

14. Line No.	15. Describe Procedure, Supply, Drug To Be Provided or Diagnosis Description	16. Procedure, Supply, Drug or Diagnosis Code*	17. Units of Service	18. Leave Blank Authorized Units	19. Amount	20. Leave Blank Authorized Amount	21. Leave Blank Status
01							
02							
03							
04							
05							

IF THE PROVIDER OF THESE SERVICES WILL BE OTHER THAN THE PROVIDER NAMED IN BOX 9, PLEASE COMPLETE THIS PORTION.

22. Provider Name	23. Telephone No.	24. Provider No.	25. Pay to Provider No.
26. Street Address		City / State / Zip	

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the recipient's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the recipient continues to be eligible for Medicaid.

27. Requesting provider

_____ _____

Signature of Authorized Representative — Date

FISCAL AGENT USE ONLY

28. MEDICAID BENEFITS ARE HEREBY ❑ APPROVED ❑ DENIED FOR THE RECIPIENT UNDER TITLE XIX, THIS AUTHORIZATION APPLIED ONLY TO THE ELIGIBLE PERSON ABOVE FOR THE SERVICE(S) SPECIFICALLY APPROVED ABOVE.

29. Comments or Reasons for Denial of Benefits

*PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODES AUTHORIZED ON THIS REQUEST MUST BE THE SAME CODES ENTERED ON THE CLAIM FORM

30. Signature

_____ _____

Fiscal Agent's Authorized Representative — Date

470-0829 (Rev. 4/98)

Page 4 was intentionally left blank.

13. REASON FOR REQUEST
Provide the required information in this area for the type of approval being requested. Refer to Chapter E of this manual.

SERVICES TO BE AUTHORIZED

14. LINE NO.
No entry is required.

15. DESCRIBE PROCEDURE, SUPPLY, DRUG TO BE PROVIDED OR DIAGNOSIS DESCRIPTION
Enter the description of the service or services to be authorized.

16. PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODE
Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.

17. UNITS OF SERVICE
Complete with the amount or number of times the service is to be performed.

18. AUTHORIZED UNITS
Leave blank. The fiscal agent will indicate the number of authorized units.

19. AMOUNT
Enter the amount that will be charged for this line item.

20. AUTHORIZED AMOUNT
Leave blank. The fiscal agent will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.

21. STATUS
Leave blank. The fiscal agent will indicate “A” for approved or “D” for denied.

22. PROVIDER NAME
Complete the name of the provider who will provide services, if other than requestor of prior authorization.

23. TELEPHONE NO.
Enter the telephone number of the provider who will provide services, if other than requestor of prior authorization. This area is optional.

24. PROVIDER NO.
Enter the seven-digit Medicaid provider number of the treating provider, if other than requestor of prior authorization.

25. PAY TO PROVIDER NO.
Enter the seven-digit group provider number for the treating provider, if other than requestor of prior authorization.

26. STREET ADDRESS, CITY, STATE, ZIP
Complete the street address, city, state and zip of the provider who will provide services, if other than requestor of prior authorization.

27. REQUESTING PROVIDER
Enter the signature of the provider or authorized representative requesting prior authorization. Also, indicate the date the request was signed.

FISCAL AGENT USE ONLY

28. MEDICAID BENEFITS REQUESTED ARE HEREBY
Do not complete. The fiscal agent will complete this item after evaluating the request.

29. COMMENTS OR REASON FOR DENIAL OF BENEFITS
Do not complete. The fiscal agent will complete this section should this request be denied.

30. SIGNATURE
Do not complete. The person making the final decision on this request will sign and date.

D. Electronic Prior Authorization Requests

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for prior authorization requests (278 transaction). However, there is no standard to use in submitting additional documentation electronically. Therefore, if you want to submit a prior authorization request electronically, the additional documentation must be submitted on paper using the following procedure:

- Staple the additional information to form 470-3970, *Prior Authorization Attachment Control*. (See the previous page for an example of this form.)
- Complete the "attachment control number" with the same number submitted on the electronic prior authorization request. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the request, please contact the person in your facility responsible for electronic claims billing.
- Mail the *Prior Authorization Attachment Control* with attachments to:

  ACS State Healthcare
  P.O. Box 14422
  Des Moines, IA 50306-3422

  Or FAX the information to the Prior Authorization Unit at: 515-327-5127

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

Iowa Medicaid Program

Prior Authorization Attachment Control

Please use this form when submitting a prior authorization electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic prior authorization. Otherwise the electronic prior authorization and paper attachment cannot be matched up.

Attachment Control Number

Provider Name _____

Pay-to-Provider Number

Recipient Name _____

Recipient State ID Number

Date of Service ____/____/_____

Type of Document

_____

_____

_____

RETURN THIS DOCUMENT WITH ATTACHMENTS TO:
ACS State Healthcare
P.O. Box 9157
Des Moines, IA 50306-3422
PA FAX: 515-327-5127

II. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**OPTIONAL** – Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** – Enter the recipient's Medicaid ID number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	**REQUIRED** – Enter the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.

4.	INSURED'S NAME	**CONDITIONAL*** – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident. **Note:** This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	**OPTIONAL** – Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**CONDITIONAL*** – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	**CONDITIONAL*** – Enter the address and phone number of the insured person indicated in field number 4.
8.	PATIENT STATUS	**OPTIONAL** – Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**CONDITIONAL*** – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program.
10.	IS PATIENT'S CONDITION RELATED TO	**CONDITIONAL*** – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** – No entry required.

11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**CONDITIONAL*** – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**CONDITIONAL** – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29. If you have received a denial of payment from another insurance, check both "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
14.	DATE OF CURRENT ILL-NESS, INJURY, PREGNANCY	**CONDITIONAL*** – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS…	**CONDITIONAL** – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK…	**OPTIONAL** – No entry required.

17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL** – Required if the referring physician does not have a Medicaid number.
17a.	ID NUMBER OF REFERRING PHYSICIAN	**CONDITIONAL*** – If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number. If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician. If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.
18.	HOSPITALI-ZATION DATES RELATED TO…	**OPTIONAL** – No entry required.
19.	RESERVED FOR LOCAL USE	**REQUIRED** – If the patient is pregnant, write "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** – No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses.
22.	MEDICAID RESUBMISSION CODE…	**OPTIONAL** – No entry required.
23.	PRIOR AUTHORIZATION NUMBER	**CONDITIONAL*** – Enter the prior authorization number issued by Consultec.

24. A	DATE(S) OF SERVICE	**REQUIRED** – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility

24. C	TYPE OF SERVICE	**OPTIONAL** – No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged.
24. E	DIAGNOSIS CODE	**REQUIRED** – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** – Enter the usual and customary charge for each line item.
24. G	DAYS OR UNITS	**REQUIRED** – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**OPTIONAL*** – Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	EMG	**OPTIONAL** – No entry required.
24. J	COB	**OPTIONAL** – No entry required.
24. K	RESERVED FOR LOCAL USE	**CONDITIONAL*** – Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** – No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.

27.	ACCEPT ASSIGNMENT?	**OPTIONAL** – No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**CONDITIONAL*** – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim.
30.	BALANCE DUE	**REQUIRED*** – Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY…	**CONDITIONAL** – If other than a home or office, enter the name and address of the facility where the service(s) were rendered.
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME…	**REQUIRED*** – Enter the complete name and address of the billing physician or service supplier.
	GRP #	**REQUIRED** – Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line.
BACK OF FORM	NOTE	**REQUIRED** – The back of the claim form must be intact on every claim form submitted.

B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

C. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- Staple the additional information to form 470-3969, *Claim Attachment Control*. (See the page following the claim form for an example of this form.)
- Complete the "attachment control number" with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- Do not attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:

  ACS State Healthcare
  P.O. Box 14422
  Des Moines, IA 50306-3422

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

Provider Name _____

Pay-to-Provider Number

Recipient Name _____

Recipient State ID Number

Date of Service ____/____/_____

Type of Document

_____

_____

_____

RETURN THIS DOCUMENT WITH ATTACHMENTS TO:
ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422

III. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following pages.)

MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 06/12/97

REMITTANCE ADVICE

(1.) TO: [redacted] (2.) R.A. NO.: 0000006 (3.) DATE PAID: 05/19/97 (4.) PROVIDER NUMBER: [redacted] (5.) PAGE: 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* (6.) CLAIM TYPE: HCFA 1500						* (7.) CLAIM STATUS: PAID							
ORIGINAL CLAIMS:			(10.)			(11.)	(12.)	(13.)	(14.)	(15.)		(16.)	
[redacted] (8.)	[redacted]	(9.) [redacted]	4-96331-00-053-0038-00			38.00	0.00	16.06	0.00	860600608B		900	000
		(17.) 01	(18.) 10/3 (19.)	99212	(20.) 1	(21.) 38.00	(22.) 0.00	(23.) 16.06	(24.) 0.00	(25.) [redacted]			000 000
[redacted]	[redacted]	[redacted]	4-96348-00-018-0060-00			50.00	0.00	35.26	0.00	860600608B			000 000
		01	11/15/96	J1055	1	41.00	0.00	33.18	0.00	[redacted]	(26.)	F	000 000
		02	11/15/96	90782	1	9.00	0.00	2.08	0.00	[redacted]		F	000 000

(27.)

REMITTANCE TOTALS					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	---------	88.00	51.32
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					51.32

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

(28.) 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 20 was intentionally left blank.

C. Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21. Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

B Billed charge
F Fee schedule
M Manually priced
N Provider charge rate
P Group therapy
Q EPSDT total screen over 17 years
R EPSDT total screen under 18 years
S EPSDT partial screen over 17 years
T EPSDT partial screen under 18 years
U Gynecology fee
V Obstetrics fee
W Child fee

27. Remittance totals (found at the end of the *Remittance Advice*):

- Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
- Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
- Number of denied original claims and amount billed by provider.
- Number of denied adjusted claims and amount billed by provider.
- Number of pended claims (in process) and amount billed by provider.
- Amount of check.

28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

IV. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice,* and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice,* use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire *Remittance Advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❒ Other pertinent information for possible claim reprocessing.

INQUIRY A

1. 17-DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FISCAL AGENT RESPONSE

INQUIRY B

1. 17–DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FISCAL AGENT RESPONSE

Provider Signature/Date:	**MAIL TO: ACS P. O. BOX 14422 DES MOINES IA 50306-3422**	**ACS Signature/Date:**

Provider Please Complete:

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR ACS USE ONLY)

PR Inquiry Log #_____

Received Date Stamp:

Page 26 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.

❑ CLAIM ADJUSTMENT	❑ CLAIM CREDIT	❑ CANCELLATION OF ENTIRE REMITTANCE ADVICE
♦ Attach a complete copy of claim. (If electronic, use next step.) ♦ Attach a copy of the Remittance Advice with corrections in **red ink**. ♦ Complete Sections B and C.	♦ Attach a copy of the Remittance Advice. ♦ Complete Sections B and C.	♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ♦ Attach the check and Remittance Advice. ♦ Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN																	

2. Pay-to Provider #:	4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

SECTION C:	Provider/Representative Signature:
	Date:

FISCAL AGENT USE ONLY: REMARKS/STATUS

Return All Requests To:

ACS
PO Box 14422
Des Moines, IA 50306-3422

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-67
Employees' Manual, Title 8
Medicaid Appendix

May 22, 1998

OPTOMETRIC SERVICES MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Optometric Services Manual***, Table of Contents (pages 4 and 5), revised; and Chapter F, *Billing and Payment*, pages 1 through 23, revised.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from the ***Optometric Services Manual***, and destroy them:

Page	Date
Contents (pages 4 and 5)	April 1, 1992
Chapter F	
1	April 1, 1992
2	7/86
3-7	April 1, 1992
8	Undated
9, 10	12/90
11-20	April 1, 1992
21	Undated
22	04/04/92
23	03/28/92
24	04/04/92
25, 26	April 1, 1992

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-190
Employees' Manual, Title 8
Medicaid Appendix

August 6, 2002

OPTOMETRIST AND OPTICIAN SERVICES MANUAL TRANSMITTAL NO. 02-1

ISSUED BY: Bureau of Managed Care and Clinical Services

SUBJECT: ***OPTOMETRIST AND OPTICIAN SERVICES MANUAL***, Title page, revised; Table of Contents (pages 4 and 5), revised; Chapter E, *Coverage and Limitations*, pages 1 through 19, revised; and pages 20 through 23, new; and Chapter F, *Billing and Payment*, pages 1 through 23, revised; and pages 24 through 27, new.

The Medicaid provider manuals for optometric services and optical services are now updated and combined into one provider manual, called the ***OPTOMETRIST AND OPTICIAN SERVICES MANUAL***. The ***OPTICAL SERVICES*** manual is obsolete.

This revision:

- Adds more frequent lens corrections for children under 8 years of age.
- Adds protective lenses for children under 8 years of age and for other recipients who have a diagnosis related disability or illness where regular lenses would pose a safety risk.
- Adds more frequent frames for children under 7 years of age.
- Adds safety frames for children under 8 years of age and for other recipients who have a diagnosis related disability or illness where regular frames would pose a safety risk.
- Adds more frequent contact lenses for children with aphakia under 4 years of age.
- Limits replacement of glasses lost or damaged beyond repair for adults age 21 and over.

Date Effective

July 1, 2002

Material Superseded

Remove the entire Chapter E and Chapter F from the ***OPTOMETRIC SERVICES*** manual and destroy them. This includes the following pages:

Page	Date
Table of Contents (pages 4 and 5)	May 1, 1998
Chapter E	
1	April 1, 1990
2-4	February 1, 1990
5	October 1, 1993

6	February 1, 1990
7	April 1, 1990
8, 9	February 1, 1990
10	April 1, 1990
11	October 1, 1993
12, 12a, 12b	April 1, 1992
13	November 1, 1993
14	July 1, 1995
15	October 1, 1993
16	February 1, 1990
17, 18	October 1, 1993
19	July 1, 1995
Chapter F	
1-23	May 1, 1998

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS/Consultec
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-231
Employees' Manual, Title 8
Medicaid Appendix

August 26, 2003

OPTOMETRIST AND OPTICIAN SERVICES MANUAL TRANSMITTAL NO. 03-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***OPTOMETRIST AND OPTICIAN SERVICES MANUAL***, Table of Contents, page 5, revised; Chapter E, *Coverage and Limitations*, pages 2, 11 through 15, 17, and 23, revised; Chapter F, *Billing and Payment*, pages 14, 23, 24, 25, and 27, revised; and pages 6a, 6b, and 16a, new.

The following changes related to HIPAA are incorporated into the manual:

- Procedure code W0045, small frames is replaced with V2025, deluxe frames. Iowa Medicaid defines deluxe frames as "wrap-around" frames for use by small children up to two years of age.
- The "W" procedure codes for nonroutine eye examinations are replaced with CPT codes for intermediate and comprehensive eye examinations. Eye examinations for a complaint or physical symptom are covered in addition to intermediate and comprehensive examinations when the diagnosis indicates the condition.
- The "Z1" modifier is replaced with "EP" for services provided as a result of a Care for Kids (EPSDT) examination.

Chapter F has been revised to add instructions for forms 470-3969, *Claim Attachment Control*, and 470-3970, *Prior Authorization Attachment Control*, used to submit paper attachments for an electronic claim or prior authorization request.

Both chapters have been revised to replace references to "Consultec" with "ACS."

Date Effective

July 1, 2003

Material Superseded

Remove the following pages from ***OPTOMETRIST AND OPTICIAN SERVICES MANUAL*** and destroy them:

Page	Date
Table of Contents (page 5)	July 1, 2002
Chapter E	
2, 11-15, 17, 23	July 1, 2002

Chapter F

14, 23, 24	July 1, 2002
25 (470-3744)	4/00
27 (470-0040)	4/00

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet Access, you may request a paper copy of this Manual Transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.